108TH CONGRESS
2D SESSION

# S. 2421

To modernize the health care system through the use of information technology and to reduce costs, improve quality, and provide a new focus on prevention with respect to health care.

---

IN THE SENATE OF THE UNITED STATES

MAY 13, 2004

Mr. KENNEDY introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

---

# A BILL

To modernize the health care system through the use of information technology and to reduce costs, improve quality, and provide a new focus on prevention with respect to health care.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Modernization, Cost Reduction, and Quality Improvement Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

# TITLE I—INFORMATION TECHNOLOGY

## Subtitle A—Improving the Quality of Health Care Through Clinical Informatics

### SEC. 101. IMPROVING THE QUALITY OF HEALTH CARE THROUGH CLINICAL INFORMATICS.

(a) GRANTS TO ENHANCE THE USE OF CLINICAL INFORMATICS.—

(1) IN GENERAL.—The Secretary shall award grants or cooperative agreements to eligible entities to assist such entities to acquire, develop, enhance, or implement (including the training of personnel needed for effective implementation) qualified clinical informatics systems that are consistent with the technical standards promulgated by the Secretary under subsection (d).

(2) DEFINITION.—In this section, the term ''qualified clinical informatics system'' means a computerized system (including both hardware and software components of such system) that—

(A) maintains and provides immediate access to patients' medical records in an electronic format;

(B) permits a qualified practitioner who wishes to enter an order for a medication, treatment, diagnostic procedure, or other intervention or service to enter such order via a computer that is linked to a database capable of accessing the medical record of the patient who is intended to receive such medication, treatment, diagnostic procedure, or other intervention;

(C) incorporates error notification software so that a warning is generated by such system if an order is entered that is likely to lead to a significant adverse outcome for the patient;

(D) provides information to a qualified practitioner regarding optimal or recommended alternatives to an order described in subparagraph (B), provided that such information is not primarily commercial in nature;

(E) provides electronic alerts and reminders to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments;

(F) allows the secure electronic transmission of information to other health care providers.

(3) GUIDANCE.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and such other officials as may be appropriate, shall provide technical guidance concerning the elements described in paragraph (2).

(4) ENTITIES ELIGIBLE FOR GRANTS OR COOPERATIVE AGREEMENTS.—To be eligible to receive a grant or cooperative agreement under this subsection, an entity shall—

(A) be a—

(i) Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4));

(ii) nonprofit hospital, health care clinic, skilled nursing facility, or other nonprofit health care facility determined by the Secretary to be eligible and to be in need of significant financial assistance to implement a qualified clinical informatics system; or

(iii) group practice as defined in section 1877(h)(4) of the Social Security Act (42 U.S.C. 1395nn(h)(4)), including a practice that meets the requirements of

such section except that such practice has only one physician, and that is in need of significant assistance to implement a qualified clinical informatics system;

(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the qualified clinical informatics system that the entity intends to implement using amounts received under paragraph (1); and

(C) submit assurances satisfactory to the Secretary that the entity will conduct the quality improvement activities described in subsection (e)(1)(A) and subsection (e)(1)(B) if applicable.

(5) MATCHING REQUIREMENT.—The Secretary may not make an award under paragraph (1) to an entity described in paragraph (4)(A) unless that entity agrees that, with respect to the costs to be incurred by the entity in carrying out the activities for which the grant or cooperative agreement is being awarded, the entity will make available (directly or through donations from public or private entities)

non-Federal contributions toward such costs in an amount equal to—

(A) with respect to an entity described in paragraph (4)(A)(i), $1 for each $10 of Federal funds provided under the grant or cooperative agreement; and

(B) with respect to an entity described in paragraph (4)(A)(ii) or (iii), $1 for each $5 of Federal funds provided under the grant or cooperative agreement.

(b) REVOLVING LOAN FUND TO ENHANCE CLINICAL INFORMATICS.—

(1) ESTABLISHMENT OF REVOLVING LOAN FUND.—The Secretary shall establish a revolving loan fund—

(A) from which the Secretary shall make loans (subject to the conditions described in paragraph (3)) to eligible entities to assist such entities to acquire, develop, enhance, or implement (including the training of personnel needed for effective implementation) qualified clinical informatics systems that are consistent with the technical standards promulgated by the Secretary under subsection (d); and

(B) into which all payments, interest, charges, and other amounts collected from loans made under subparagraph (A) shall, notwithstanding any other provision of law, be deposited.

(2) ELIGIBLE ENTITIES.—To be eligible to receive a loan under this subsection, an entity shall—

(A) be a—

(i) nonprofit hospital, health care clinic, community health center, skilled nursing facility, or other nonprofit health care facility; or

(ii) group practice as defined in section 1877(h)(4) of the Social Security Act (42 U.S.C. 1395nn(h)(4)), including a practice that meets the requirements of such section except that such practice has only one physician;

(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the qualified clinical informatics system that the entity intends to implement using amounts received under paragraph (1); and

(C) submit assurances satisfactory to the Secretary that the entity will conduct the quality improvement activities described in subsection (e)(1)(A) and subsection (e)(1)(B) if applicable.

(3) CONDITIONS OF LOANS.—

(A) IN GENERAL.—Each loan under this subsection shall be made at a rate of interest that is the greater of—

(i) a rate that is 3 percentage points below the rate of interest payable on obligations of the Federal Government having terms of maturity of 10 years; or

(ii) zero.

(B) TERM.—Each loan made under this subsection shall be for a term that does not exceed 7 years.

(C) REPAYMENT.—The Secretary may not make a loan to an eligible entity under this subsection unless the Secretary determines that there is a reasonable expectation that the entity will repay the loan according to the terms of the loan.

(D) COLLATERAL.—The Secretary may require an eligible entity receiving a loan under

this subsection to provide such collateral as the Secretary determines to be necessary to secure the loan.

(E) DEFAULTS AND COLLECTIONS.—Prior to making a loan under this subsection, the Secretary shall establish written procedures and definitions relating to defaults and collections of payments on such loans and shall provide to each applicant for such a loan, at the time of the application, a written copy of such procedures and definitions.

(F) REGULATIONS.—The Secretary may promulgate such other regulations as may be necessary to carry out the purposes of this subsection, including regulations involving reporting and auditing.

(4) SEPARATE ACCOUNT AND INVESTMENTS.—The revolving loan fund established under this subsection shall be maintained by the Secretary as a separate account. Any portion of the revolving loan fund that is not required for expenditure shall be invested in obligations of the United States or in obligations guaranteed or insured by the United States.

(c) LOAN GUARANTEES.—

(1) IN GENERAL.—The Secretary shall establish a program under which the Secretary may guarantee up to 90 percent of the principal and interest on loans made by non-Federal lenders to eligible entities for the costs of acquiring qualified clinical informatics systems.

(2) ELIGIBLE ENTITIES.—To be eligible to receive a loan guarantee under this subsection, an entity shall—

(A) be a—

(i) nonprofit hospital, health care clinic, community health center, skilled nursing facility, or other nonprofit health care facility; or

(ii) group practice as defined in section 1877(h)(4) of the Social Security Act (42 U.S.C. 1395nn(h)(4)), including a practice that meets the requirements of such section except that such practice has only one physician;

(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the qualified clinical informatics system that

the entity intends to implement using amounts received under paragraph (1); and

(C) submit assurances satisfactory to the Secretary that the entity will conduct the quality improvement activities described in subsection (e)(1)(A) and subsection (e)(1)(B) if applicable.

(3) USE OF FUNDS.—Loan funds guaranteed under this subsection may be used to acquire qualified clinical informatics systems that are consistent with the technical standards promulgated by the Secretary under subsection (d).

(4) CONDITIONS OF LOAN.—Guarantees of loans under this subsection shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this subsection will be achieved.

(d) PROMULGATION OF TECHNICAL STANDARDS.—Not later than January 1, 2006, the Secretary shall develop or adopt technical standards for qualified clinical informatics systems relating to—

(1) interoperability;

(2) security;

(3) the protection of confidentiality, consistent with the regulations promulgated under section

264(c) of the Health Insurance Portability and Accountability Act (42 U.S.C. 1320d–2 note); and

(4) such other subjects determined appropriate by the Secretary.

(e) QUALITY IMPROVEMENT ACTIVITIES.—

(1) IN GENERAL.—As used in this section, the term ''quality improvement activities'' means—

(A) the use of a qualified clinical informatics system to report data on the health care quality standards developed under section 201 of this Act to a utilization and quality control peer review organization with a contract under part B of title XI of the Social Security Act (42 U.S.C. 1320c et seq.), or to any other patient safety organization recognized by the Secretary, and to the Secretary in a manner consistent with the standards developed under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act (42 U.S.C. 1320d–2 note); and

(B) with respect to a health care provider that employs more than 50 physicians (as such term is defined in 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) or that is a hos-

pital or other institutional provider, the implementation of a program to—

(i) analyze (through a process that may include the receipt of analyses conducted by other appropriate entities) data on the quality of health care provided by such provider; and

(ii) institute measures, based on the analysis conducted under clause (i), to improve the quality of health care provided by such provider.

(2) PUBLIC AVAILABILITY OF DATA ON QUALITY IMPROVEMENT.—The Secretary shall analyze and make publicly available the data reported to the Secretary under paragraph (1)(A) in a manner determined to be of value to patients and health care practitioners.

(f) REQUIREMENTS FOR STANDARDS.—

(1) CONSULTATION.—In developing the technical standards under subsection (d), the Secretary shall consult with participants in the Consolidated Health Informatics initiative, or any successor to such initiative, and with public and private entities determined appropriate by the Secretary. In developing the standards under subsection (d), the Sec-

retary shall take into consideration applicable recommendations of—

(A) the National Committee on Vital and Health Statistics; and

(B) the Consolidated Health Informatics initiative or any successor to such initiative.

(2) OBJECTIVE.—Any standard developed or adopted under subsection (d) shall be consistent with the objectives of improving—

(A) patient safety; and

(B) the quality of care provided to patients.

(3) CONSISTENCY.—The Secretary shall ensure that, to the maximum extent practicable, the standards adopted or developed under subsection (d) shall be consistent with—

(A) any standards otherwise adopted or developed by the Secretary under the Social Security Act for transactions and data elements to enable the electronic transmission of prescriptions; and

(B) any standards adopted by the Consolidated Health Informatics initiative, or any successor to such initiative.

(4) ADDITIONS AND MODIFICATIONS TO STANDARDS.—Not later than January 1, 2007, and annually thereafter, the Secretary shall review the standards developed or adopted under subsection (d), and may modify such standards and measures if determined appropriate. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

(g) RESPONSIBILITIES OF THE SECRETARY.—

(1) RESEARCH ON EFFECTIVENESS.—The Secretary shall conduct research on a representative sample of entities receiving awards under subsections (a), (b), and (c) to determine the extent to which qualified clinical informatics systems implemented by such entities have improved the quality of care provided to patients receiving care from such entities and reduced the costs of providing high quality health care.

(2) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical assistance as is feasible to eligible entities in carrying out activities under this section.

(3) USE OF TECHNOLOGY SYSTEMS AND ELECTRONIC PAYMENT OF CLAIMS.—The Secretary shall, to the extent technically practicable—

(A) utilize information technology systems for—

(i) processing financial transactions;

(ii) providing reimbursement to providers;

(iii) adjudicating claims for reimbursement; and

(iv) providing statements of account or explanations of benefits to providers; and

(B) require the submission of claims for payment via electronic means.

(4) CONSISTENCY WITH STANDARDS.—Beginning on January 1, 2006, the Secretary may not purchase information technology systems unless such systems are consistent with the applicable standards developed under subsection (d).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary.

**SEC. 102. REIMBURSEMENT FOR OPERATION OF QUALIFIED CLINICAL INFORMATICS SYSTEM.**

(a) INCREASED REIMBURSEMENT FOR OPERATING CLINICAL INFORMATICS SYSTEM.—

(1) IN GENERAL.—The Secretary shall increase, by the amount specified in paragraph (2), the reimbursement provided under any Federal health program to any provider that—

(A) operates a qualified clinical informatics system that is consistent with the technical standards promulgated under section 101(d); and

(B) conducts the quality improvement activities described in section 101(e)(1)(A) and section 101(e)(1)(B) if applicable.

(2) AMOUNT OF INCREASED REIMBURSEMENT.—The amount of the increase in a reimbursement under paragraph (1) shall be equal to—

(A) for fiscal year 2005, 1 percent of the amount of the reimbursement involved;

(B) for fiscal year 2006, 0.8 percent of the amount of the reimbursement involved;

(C) for fiscal year 2007, 0.6 percent of the amount of the reimbursement involved;

(D) for fiscal year 2008, 0.4 percent of the amount of the reimbursement involved; and

(E) for fiscal year 2009, 0.2 percent of the amount of the reimbursement involved.

(b) DECREASED REIMBURSEMENT FOR FAILURE TO OPERATE A CLINICAL INFORMATICS SYSTEM.—

(1) IN GENERAL.—The Secretary shall decrease, by the amount specified in paragraph (2), the reimbursement provided under any Federal health program to any provider unless such provider—

(A) operates a qualified clinical informatics system that is consistent with the technical standards promulgated under section 101(d); and

(B) conducts the quality improvement activities described in section 101(e)(1)(A) and section 101(e)(1)(B) if applicable.

(2) AMOUNT OF DECREASED REIMBURSEMENT.—The amount of the decrease in a reimbursement under paragraph (1) shall be equal to—

(A) for fiscal year 2010, 0.2 percent of the amount of the reimbursement involved;

(B) for fiscal year 2011, 0.4 percent of the amount of the reimbursement involved;

(C) for fiscal year 2012, 0.6 percent of the amount of the reimbursement involved;

(D) for fiscal year 2013, 0.8 percent of the amount of the reimbursement involved; and

(E) for fiscal year 2014, and each subsequent fiscal year, 1.0 percent of the amount of the reimbursement involved.

(c) LIMITATION.—Subsection (b) shall not apply to any provider that employs less than 50 health care professionals.

# Subtitle B—Reducing Administrative Costs and Improving Service Through Information Technology

### SEC. 111. REQUIREMENT FOR HEALTH INSURERS TO IMPLEMENT COMPUTERIZED CLAIMS PROCESSING SYSTEMS.

(a) IN GENERAL.—Not later than December 31, 2008, each group health plan and health insurance issuer offering health insurance coverage shall have in effect an automated, integrated system that allows for efficient and effective adjudication of claims and the detection of fraud and abuse in accordance with this section.

(b) ELEMENTS OF ADJUDICATION.—The system described in subsection (a) shall include determinations concerning payments and coverage for items or services under the terms and conditions of the plan or coverage involved,

including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim.

(c) TIMEFRAME.—The plan or issuer shall complete the adjudication of claims under this section immediately after the plan or issuer receives—

(1) the claim; and

(2) any additional information requested by the plan or issuer that is necessary to make a determination relating to the claim.

(d) ACCURACY.—In adjudicating claims under this section the plan or issuer shall ensure that—

(1) such claims are adjudicated with an accuracy of at least 99 percent;

(2) the plan or issuer has the ability to accept claims submitted via the Internet; and

(3) the plan or issuer has the ability to issue denials where necessary instantaneously via the Internet, and to provide an opportunity for challenge to and resolution of such denials (except in cases of dispute over medical necessity) via the Internet.

(e) DETECTION SYSTEM.—Not later than December 31, 2008, each group health plan and health insurance issuer offering health insurance coverage shall use the system described in subsection (a) to detect fraud and abuse

in real-time as part of the adjudication of claims under this section.

(f) REGULATIONS.—The Secretary shall issue such regulations as may be necessary or appropriate to carry out this section.

**SEC. 112. MAKING HEALTH CARE MORE RESPONSIVE TO THE CONSUMER.**

(a) STATEMENT OF ACCOUNT FOR CONSUMERS.—

(1) IN GENERAL.—Not later than December 31, 2008, each group health plan and health insurance issuer offering health insurance coverage shall have in effect a computerized system that provides each participant, beneficiary, or enrollee with a statement of account that—

(A) includes information, with respect to the participant, beneficiary, or enrollee, on—

(i) claims received, claims denied, and the reasons for any denials;

(ii) status of coverage; and

(iii) deductible information; and

(B) is issued quarterly.

(2) INTERNET ACCESS.—The plan or issuer may comply with this subsection by making the quarterly statements available on the Internet 24 hours a day, 7 days a week, through a secure website.

(b) STATEMENT OF ACCOUNT FOR EMPLOYERS AND PURCHASES.—Not later than December 31, 2008, each group health plan and health insurance issuer shall have in effect a computerized system to provide to employers and other purchasers of health insurance products a statement of account that—

(1) includes—

(A) current information on coverage status; and

(B) reports of customer satisfaction that are updated annually; and

(2) is available 24 hours a day, 7 days a week, through—

(A) the Internet through a secure website; or

(B) a toll-free telephone number.

(c) INTERNET ENROLLMENT.—

(1) IN GENERAL.—Not later than December 31, 2008, each group health plan and health insurance issuer shall have in effect a computerized system to provide to employers and other purchasers of health insurance products an option to enroll for coverage under such health insurance products on the Internet through a secure website.

(2) ELIGIBILITY REQUIREMENTS.—The Internet website described in paragraph (1) shall include information on eligibility requirements for coverage.

(d) CONSUMER EXPLANATION OF BENEFITS.—

(1) IN GENERAL.—Not later than December 31, 2008, each group health plan and health insurance issuer shall have in effect a computerized system to provide, to a participant, beneficiary, or enrollee—

(A) an explanation of benefits at the point of service or not later than 48 hours after the time that service is provided; and

(B) a description of the coverage and cost of each services provided to the participant, beneficiary, or enrollee under the plan or coverage.

(2) LANGUAGE.—Any explanation of benefits under this subsection shall be provided in a printed form and written in a manner calculated to be understood by the average participant, beneficiary, or enrollee.

(e) REFERRALS AND AUTHORIZATIONS.—

(1) IN GENERAL.—Not later than December 31, 2008, each group health plan and health insurance issuer shall have in effect a computerized system for making and checking referrals and pre-authoriza-

tions where such referrals and pre-authorizations are required under the plan or coverage.

(2) ACCESS.—The system described in paragraph (1) shall permit access by physicians and by participants, beneficiaries, and enrollees to information on the completion of referrals and pre-authorizations and whether health care services and products have been authorized, through—

(A) the Internet through a secure website; or

(B) a toll-free telephone number.

(f) MODERNIZING FINANCIAL TRANSACTIONS IN HEALTH CARE.—Not later than December 31, 2008, each group health plan and health insurance issuer offering health insurance coverage shall have in effect a computerized system that—

(1) permits health care providers to receive claim payments through electronic transfer of funds;

(2) permits participants, beneficiaries, and enrollees to make payments for deductibles or other required cost sharing through electronic transfer of funds; and

(3) provides automated, integrated audit controls to monitor any duplicate payments or overpayments within the adjudication system.

**SEC. 113. REGULATIONS.**

The Secretary shall issue such regulations as may be necessary or appropriate to carry out this subtitle.

# Subtitle C—Application to Public Health Service Act and Employee Retirement Income Security Act of 1974

**SEC. 121. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT.**

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

**''SEC. 2707. IMPROVED QUALITY AND REDUCED COSTS.**

''Each group health plan shall comply with the requirements under title I of the Health Care Modernization, Cost Reduction, and Quality Improvement Act, and each health insurance issuer shall comply with health care modernization requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

**SEC. 122. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT.**

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

**"SEC. 2753. IMPROVED QUALITY AND REDUCED COSTS.**

''Each health insurance issuer shall comply with requirements under title I of the Health Care Modernization, Cost Reduction, and Quality Improvement Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

**SEC. 123. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.**

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

**"SEC. 714. IMPROVED QUALITY AND REDUCED COSTS.**

''(a) IN GENERAL.—A group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Health Care Moderniza-

tion, Cost Reduction, and Quality Improvement Act (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of title I of the Health Care Modernization, Cost Reduction, and Quality Improvement Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(c) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under the other provisions of this title.''.

(b) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711, 714, and 715''.

(2) TABLE OF CONTENTS.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Improved quality and reduced costs.''.

# Subtitle D—Miscellaneous Provisions

**SEC. 131. DEFINITIONS.**

In this title:

(1) CLAIM.—The term ''claim'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(2) COST SHARING.—The term ''cost-sharing'' means any deductibles, coinsurance, copayment amounts, and liability for balance billing, for which the participant, beneficiary, or enrollee will be responsible.

(3) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(4) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in

section 733(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)).

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' has the meaning given such term in section 1855(d)(5) of the Social Security Act.

(6) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' has the meaning given such term in section 733(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)).

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

# TITLE II—PAYING FOR PERFORMANCE

**SEC. 201. HEALTH CARE PROVIDER QUALITY STANDARDS.**

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish quality standards for health care providers to be used as an element of payment or reimbursement for health care items or services, including providers providing

items or services that are paid for by the Federal Government.

(2) REQUIREMENTS.—Standards under paragraph (1) shall—

(A) be selected and developed in consultation with the National Quality Advisory Council, other Federal agencies, and the private sector;

(B) be established in any area where such a standard is determined by the Secretary to be feasible and appropriate as a basis for payment or reimbursement;

(C) be periodically revised and updated; and

(D) include standards relating to the process and outcome of care, as determined feasible and appropriate by the Secretary.

(3) APPROPRIATENESS.—In determining feasibility and appropriateness under paragraph (2)(B), the Secretary shall take into account the cost of determining compliance with the standard relative to the benefit of such standard.

(b) PAYMENTS BASED ON COMPLIANCE WITH STANDARDS.—

(1) IN GENERAL.—Each health care payor—

(A) shall, except as provided in subsection (c), provide enhanced payments to health care providers that achieve or make appropriate progress toward compliance with the applicable quality standards developed under subsection (a); and

(B) may provide for reduced payments to health care providers that fail to make appropriate progress toward, or fail to comply with, such standards.

(2) FLEXIBILITY.—In determining whether to provide enhanced or reduced payments under paragraph (1), the health care payor may provide for a time-limited period in which—

(A) compliance with the standards are voluntary for the health care provider involved; and

(B) with respect to a health care provider that has failed to comply with the standards, the provider may achieve compliance with the standard in order to gain an enhanced payment or avoid a reduced payment.

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to—

(A) prohibit a health care payor from making payments to health care providers for their performance based on standards in addition to the standards developed under subsection (a); and

(B) prohibit a health care payor from reducing payments to health care providers who do not meet the standard, unless specifically prohibited by the Secretary.

(c) AUTHORITY TO LIMIT TO CERTAIN CATEGORIES OR TYPES OF PROVIDERS.—Each health care payor may—

(1) limit the requirement for enhanced payments based on compliance with a standard developed under subsection (a) to certain categories or types of health care providers;

(2) establish alternative standards applicable to the same condition or course of treatment for different types or categories of health care providers; and

(3) provide for exceptions to the requirements for enhanced payments based on circumstances in which payment based on a standard would not serve the public interest.

(d) MANDATORY NEGOTIATION OF PAYMENT FOR VALUE.—

(1) IN GENERAL.—If a health care provider determines—

(A) that, notwithstanding the standards developed under subsection (a), it can provide health care items or services in a manner that will reduce cost and improve the quality of care; and

(B) that providing the items or services described in subparagraph (A) will reduce the amount of reimbursement that would otherwise be available to the provider;

the provider may request that the payor involved enter into negotiations to establish an alternative basis of payment.

(2) GOOD FAITH NEGOTIATION.—A payor that pays for items or services described in paragraph (1) shall negotiate an alternative basis of payment for health care items or services in good faith. Nothing in the preceding sentence shall be construed to require any payor to agree to a particular method of payment or a level of payment that would result in increased total costs to the payor.

(e) SPECIAL STANDARDS FOR CHRONIC CARE.—

(1) IN GENERAL.—Standards developed under subsection (a) for chronic care shall include—

(A) coordination of care;

(B) patient education in self-management; and

(C) systems for tracking and assuring achievement of process and outcome objectives.

(2) CONTRACTS.—In carrying out this subsection, health care payors shall enter into contracts with health care providers that are willing to accept responsibility for the outcome of care for specific individuals and shall make standards-based payments to such providers. Such payments shall cover the costs of services, such as training in patient self-management and coordination of care, either directly or through payments to a contracting provider, pursuant to standards specified by the Secretary.

(f) HEALTH CARE PAYOR.—In this section, the term ''health care payor'' means any entity that pays for, or reimburses others for payment to, a health care provider for health care items or services, including a health insurance issuer and the Federal Government.

(g) REPORTING REQUIREMENTS.—

(1) IN GENERAL.—Each health care provider to which this section applies shall report to the Sec-

retary data on the compliance of the provider with this section, including data on the quality of health care provided by such provider and measures to improve the quality of health care provided by such provider.

(2) PUBLIC AVAILABILITY OF DATA.—The Secretary shall analyze and make publicly available the data reported to the Secretary under paragraph (1) in a manner determined to be of value to patients and health care practitioners.

# TITLE III—TARGETED QUALITY INITIATIVES

### SEC. 301. IMPROVING THE QUALITY OF CARE FOR AMERICANS WITH DIABETES.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

### "PART R—IMPROVING THE QUALITY OF CARE FOR AMERICANS WITH DIABETES

### "SEC. 399A. STATE DIABETES CONTROL AND PREVENTION PROGRAMS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with appropriate agencies, shall support comprehensive diabetes control and preven-

tion programs by awarding grants to eligible entities to provide public health surveillance, prevention, and control activities, and to assure affordable, high-quality diabetes care.

''(b) ELIGIBILITY.—A State or territory is an eligible entity under this section.

''(c) USE OF FUNDS.—Consistent with the comprehensive diabetes control and prevention plan submitted under subsection (d), an eligible entity that receives a grant under this section may use funds received under such grant to—

''(1) conduct health and community research, including research on behavioral interventions, to prevent diabetes (including the development of related complications) and the onset of type 2 diabetes in persons with pre-diabetes or persons at high risk for developing diabetes;

''(2) conduct projects, including community-based programs of diabetes control and prevention, and similar collaborations with academic institutions, hospitals, community centers, health insurers, researchers, health professionals, and nonprofit organizations;

''(3) conduct public health surveillance and epidemiological activities relating to the prevalence of

diabetes and assessing disparities in diabetes control and prevention, including such disparities in underserved populations;

''(4) provide public information and education programs; and

''(5) provide education and training for health professionals, including allied health professionals.

''(d) APPLICATION.—An eligible entity that seeks funding under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a comprehensive plan for diabetes-related prevention and control strategies and activities to be undertaken or supported by the eligible entity, which—

''(1) is developed with the advice of stakeholders from the public, private, and nonprofit sectors with expertise relating to diabetes control, prevention, and treatment;

''(2) is intended to reduce the incidence, morbidity, and mortality of type 1 and 2 diabetes, with a priority on preventing and controlling diabetes in at-risk populations and reducing disparities in underserved populations; and

''(3) describes the diabetes-related services and activities to be undertaken or supported by the eligible entity.

**"SEC. 399A–1. IMPROVING QUALITY OF DIABETES PREVENTION AND CARE.**

''(a) IN GENERAL.—After completion of activities under subsection (d), the Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in collaboration with the Director of the Agency for Healthcare Research and Quality, shall award competitive grants to eligible entities to apply the best practices identified by the Secretary under subsection (d) for diabetes prevention and control.

''(b) ELIGIBILITY.—An entity is eligible for a grant under this section if such entity is—

''(1) a State, territory, Indian tribe, tribal organization, public or nonprofit entity; or

''(2) a partnership of an entity described in paragraph (1) and an appropriate private sector organization.

''(c) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to eligible entities that propose to carry out programs to reduce disparities in diabetes prevention and control for high-risk or underserved populations.

''(d) BEST PRACTICES.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary shall identify evidence-based best practices, evidence-based guidelines and other effective models for diabetes prevention and control, which may be adopted and applied by eligible entities under this section.

''(2) SPECIFIC BEST PRACTICES.—Best practices, as described in paragraph (1), may include—

''(A) State or community-based interventions, school-based screening, care and prevention programs, health systems improvement strategies, and health and environmental policies that promote improved nutrition and physical activity;

''(B) case management or disease management quality improvements programs;

''(C) appropriate communication, training, or regional outreach and health promotion initiatives, including Internet-based initiatives; or

''(D) models developed or validated by diabetes research and training centers established under section 431.

''(e) APPLICATION.—An eligible entity that seeks funding under this section shall prepare and submit to the

Secretary an application at such time, in such manner, and containing such information as the Secretary determines to be necessary, including information regarding how such entity would use funds received under this section to supplement activities carried out under such entity's comprehensive diabetes control and prevention plan under section 399A.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2005, and such sums as may be necessary for each of fiscal years 2006 through 2009.

**"SEC. 399A–2. NATIONAL DIABETES EDUCATION AND OUTREACH.**

''(a) PURPOSE.—The Secretary, acting through the Diabetes Mellitus Interagency Coordinating Committee, shall coordinate a national diabetes education program to support, develop, and implement education initiatives and outreach strategies appropriate for both type 1 and 2 diabetes. Such activities may include public awareness campaigns, public service announcements and community partnership workshops, as well as programs targeted at businesses and employers, managed care organizations, and health care providers.

''(b) PRIORITY.—The Secretary shall emphasize translation of new scientific and clinical findings into uti-

lizable information for health care providers and patients. The Secretary shall also give priority to reaching high-risk or underserved populations.

''(c) COLLABORATION.—In carrying out this section, the Secretary shall consult and collaborate with stakeholders from the public, private, and nonprofit sectors with expertise relating to diabetes control, prevention, and treatment.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $15,000,000 for fiscal year 2005 and such sums as may be necessary for each of fiscal years 2006 through 2009.''.

**''SEC. 399A–3. DEFINITION.**

''In this part, the term 'State' has the meaning given such term in section 2, and includes Indian tribes.''.

**SEC. 302. IMPROVING THE QUALITY OF CARE FOR AMERICANS WITH ARTHRITIS.**

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 301, is further amended by adding at the end the following:

## "PART S—IMPROVING THE QUALITY OF CARE FOR AMERICANS WITH ARTHRITIS

### "SEC. 399B. STATE ARTHRITIS CONTROL AND PREVENTION PROGRAMS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible entities to provide support for comprehensive arthritis control and prevention programs and to enable such entities to provide public health surveillance, prevention, and control activities related to arthritis and other rheumatic diseases.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall be a State or Indian tribe.

''(c) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit to the Secretary an application at such time, in such manner, and containing such agreements, assurances, and information as the Secretary may require, including a comprehensive arthritis control and prevention plan that—

''(1) is developed with the advice of stakeholders from the public, private, and nonprofit sectors that have expertise relating to arthritis control, prevention, and treatment that increase the quality of life and decrease the level of disability;

''(2) is intended to reduce the morbidity of arthritis, with priority on preventing and controlling

arthritis in at-risk populations and reducing disparities in arthritis prevention, diagnosis, management, and quality of care in underserved populations;

''(3) describes the arthritis-related services and activities to be undertaken or supported by the entity; and

''(4) is developed in a manner that is consistent with the National Arthritis Action Plan or a subsequent strategic plan designated by the Secretary.

''(d) USE OF FUNDS.—An eligible entity shall use amounts received under a grant awarded under subsection (a) to conduct, in a manner consistent with the comprehensive arthritis control and prevention plan submitted by the entity in the application under subsection (c)—

''(1) public health surveillance and epidemiological activities relating to the prevalence of arthritis and assessment of disparities in arthritis prevention, diagnosis, management, and care;

''(2) public information and education programs; and

''(3) education, training, and clinical skills improvement activities for health professionals, including allied health personnel.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section

such sums as may be necessary for each of fiscal years 2005 through 2009.

**"SEC. 399B–1. COMPREHENSIVE ARTHRITIS ACTION GRANTS.**

"(a) IN GENERAL.—The Secretary shall award grants on a competitive basis to eligible entities to enable such eligible entities to assist in the implementation of a national strategy for arthritis control and prevention.

"(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall be a national public or private nonprofit entity.

"(c) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit to the Secretary an application at such time, in such manner, and containing such agreements, assurances, and information as the Secretary may require, including a description of how funds received under a grant awarded under this section will—

"(1) supplement or fulfill unmet needs identified in the comprehensive arthritis control and prevention plan of a State or Indian tribe;

"(2) otherwise help achieve the goals of the National Arthritis Action Plan or a subsequent strategic plan designated by the Secretary.

''(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to eligible entities submitting applications proposing to carry out programs for controlling and preventing arthritis in at-risk populations or reducing disparities in underserved populations.

''(e) USE OF FUNDS.—An eligible entity shall use amounts received under a grant awarded under subsection (a) for 1 or more of the following purposes:

''(1) To expand the availability of physical activity programs designed specifically for people with arthritis.

''(2) To provide awareness education to patients, family members, and health care providers, to help such individuals recognize the signs and symptoms of arthritis, and to address the control and prevention of arthritis.

''(3) To decrease long-term consequences of arthritis by making information available to individuals with regard to the self-management of arthritis.

''(4) To provide information on nutrition education programs with regard to preventing or mitigating the impact of arthritis.

''(f) EVALUATION.—An eligible entity that receives a grant under this section shall submit to the Secretary an evaluation of the operations and activities carried out

under such grant that includes an analysis of increased utilization and benefit of public health programs relevant to the activities described in the appropriate provisions of subsection (e).

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2005 through 2009.

**''SEC. 399B–2. NATIONAL ARTHRITIS EDUCATION AND OUTREACH.**

''(a) IN GENERAL.—The Secretary shall coordinate a national education and outreach program to support, develop, and implement education initiatives and outreach strategies appropriate for arthritis and other rheumatic diseases.

''(b) INITIATIVES AND STRATEGIES.—Initiatives and strategies implemented under the program described in paragraph (1) may include public awareness campaigns, public service announcements, and community partnership workshops, as well as programs targeted at businesses and employers, managed care organizations, and health care providers.

''(c) PRIORITY.—In carrying out subsection (a), the Secretary—

''(1) may emphasize prevention, early diagnosis, and appropriate management of arthritis, and opportunities for effective patient self-management; and

''(2) shall give priority to reaching high-risk or underserved populations.

''(d) COLLABORATION.—In carrying out this section, the Secretary shall consult and collaborate with stakeholders from the public, private, and nonprofit sectors with expertise relating to arthritis control, prevention, and treatment.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2005 through 2009.

**''SEC. 399B–3. DEFINITION.**

''In this part, the term 'State' has the meaning given such term in section 2, and includes Indian tribes.''.

**SEC. 303. STROKE PREVENTION, TREATMENT, AND REHABILITATION.**

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 302, is further amended by adding at the end the following:

**"PART T—STROKE PREVENTION, TREATMENT, AND REHABILITATION PROGRAMS**

**"SEC. 399C. DEFINITIONS.**

In this part:

''(1) STROKE CARE SYSTEM.—The term 'stroke care system' means a statewide system to provide for the diagnosis, prehospital care, hospital definitive care, and rehabilitation of stroke patients.

''(2) STROKE.—The term 'stroke' means a 'brain attack' in which blood flow to the brain is interrupted or in which a blood vessel or aneurysm in the brain breaks or ruptures.

**"SEC. 399C–1. GRANTS TO STATES FOR STROKE CARE SYSTEMS.**

''(a) GRANTS.—The Secretary shall award grants to States for the development and implementation of stroke care systems that provide high-quality prevention, diagnosis, treatment, and rehabilitation.

''(b) REQUIRED USES.—

''(1) IN GENERAL.—In carrying out activities described in subsection (a), each State that is awarded a grant under this section shall—

''(A) establish, enhance, or expand a statewide stroke care system for the purpose of ensuring access to high-quality stroke prevention, diagnosis, treatment, and rehabilitation, except

that activities conducted under this subparagraph shall be consistent with guidelines or recommendations issued by the Secretary under section 399C–3(a)(2) to the extent that such guidelines or recommendations have been issued;

''(B) establish, enhance, or expand, as appropriate, stroke care centers, except that activities conducted under this subparagraph shall be consistent with guidelines or recommendations issued by the Secretary under section 399C–3(a)(2), to the extent that such guidelines or recommendations have been issued;

''(C) conduct evaluation activities to monitor clinical outcomes and procedures and to verify resources, infrastructure, and operations devoted to stroke care;

''(D) enhance, develop, and implement a model curriculum for training emergency medical services personnel in the identification, assessment, stabilization, and prehospital treatment of stroke patients, which curriculum may, at the discretion of the State, consist of or be based on the model curriculum developed by the Secretary under section 399C–3(a)(1);

"(E) enhance coordination of emergency medical services with respect to stroke care;

"(F) establish, enhance, or improve a central data reporting and analysis system described in subsection (c);

"(G) establish, enhance, or improve a support network described in subsection (d) to provide assistance to facilities with smaller populations of stroke patients or less advanced onsite stroke treatment resources;

"(H) consult with organizations and individuals with expertise in stroke prevention, diagnosis, treatment, and rehabilitation; and

"(I) with respect to carrying out subparagraph (C) through (H), use the best available evidence and consensus recommendations of professional associations.

"(2) PERMISSIBLE USES.—In developing and implementing a stroke care system described in paragraph (1), each State that is awarded a grant under this section may—

"(A) improve existing State stroke prevention programs; and

"(B) conduct a stroke education and information campaign, including by—

''(i) making public service announcements about the warning signs of stroke and the importance of treating stroke as a medical emergency; and

''(ii) providing education regarding ways to prevent stroke and the effectiveness of stroke treatment.

''(c) CENTRAL DATA REPORTING AND ANALYSIS SYSTEM.—A central data reporting and analysis system described in this section is a system that collects data from facilities that provide direct care to stroke patients and uses the data—

''(1) to identify the number of stroke patients treated in the State;

''(2) to monitor patient care in the State for stroke patients at all phases of stroke for the purpose of evaluating the diagnosis, treatment, and treatment outcome of such stroke patients;

''(3) to identify the total amount of uncompensated and under-compensated stroke care expenditures for each fiscal year by each stroke care facility in the State;

''(4) to identify the number of acute stroke patients who receive advanced drug therapy; and

''(5) to identify patients transferred within the statewide stroke care system, including reasons for such transfer.

''(d) SUPPORT NETWORK.—A support network described in this section may include the following:

''(1) The use of telehealth technology to connect facilities described in subsection (b)(1)(G) to more advanced stroke care facilities.

''(2) The provision of neuroimaging, laboratory, and any other equipment necessary to facilitate the establishment of a telehealth network.

''(3) The use of phone consultation, where useful.

''(4) The use of referral links when a patient needs more advanced care than is available at the facility providing initial care.

''(5) The provision of any other assistance determined appropriate by the State.

''(e) RESTRICTIONS ON USE OF PAYMENTS.—The Secretary may not make payments to a State under this section for a fiscal year unless the State agrees that the payments will not be expended—

''(1) to make cash payments to intended recipients of services provided pursuant to this section;

''(2) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;

''(3) to provide financial assistance to any entity other than a public or nonprofit private entity; or

''(4) for construction, alteration, or improvement of any building or facility.

''(f) FAILURE TO COMPLY WITH AGREEMENTS.—

''(1) REPAYMENT OF PAYMENTS.—

''(A) REQUIREMENT.—The Secretary may, in accordance with paragraph (2), require a State to repay any payments received by the State under this section that the Secretary determines were not expended by the State in accordance with the agreements required to be made by the State as a condition of the receipt of the payments.

''(B) OFFSET OF AMOUNTS.—If a State fails to make a repayment required in subparagraph (A), the Secretary may offset the amount of the repayment against any amount due to be paid to the State under this section.

''(2) OPPORTUNITY FOR A HEARING.—Before requiring repayment of payments under paragraph

(1), the Secretary shall provide to the State an opportunity for a hearing.

''(g) APPLICATION REQUIREMENTS.—The Secretary may not award a grant to a State under this section unless—

''(1) the State submits an application containing agreements in accordance with this section;

''(2) the agreements are made through certification from the chief executive officer of the State;

''(3) with respect to such agreements, the application provides assurances of compliance satisfactory to the Secretary;

''(4) the application contains the plan provisions and the information required to be submitted to the Secretary; and

''(5) the application otherwise is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(h) TECHNICAL ASSISTANCE.—The Secretary shall, without charge to a State receiving payments under this section, provide to the State (or to any public or nonprofit entity designated by the State) technical assistance with respect to the planning, development, and operation of any program carried out pursuant to this section. The Sec-

retary may provide such technical assistance directly, through contracts, or through grants.

''(i) SUPPLIES AND SERVICES IN LIEU OF GRANT FUNDS.—

''(1) IN GENERAL.—Upon the request of a State receiving payments under this section, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services to the State and may detail to the State any officer or employee of the Department of Health and Human Services, for the purpose of assisting the State to achieve the purpose of the payments.

''(2) REDUCTION IN PAYMENTS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of payments to the State under this section by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Secretary. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

''(j) LIMITATION ON ADMINISTRATIVE EXPENSES.—The Secretary may not award a grant to a State under this section unless the State agrees to use not more than

10 percent of amounts received under the grant for administrative expenses.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

**''SEC. 399C–2. PLANNING GRANTS.**

''(a) GRANTS.—The Secretary may award a grant to a State to assist such State in formulating a plan to develop a stroke care system in accordance with section 399C–1 or in otherwise meeting the requirements of such section.

''(b) SUBMISSION TO SECRETARY.—The chief executive officer of a State that receives a grant under this section shall submit to the Secretary a copy of the plan developed using the amounts provided under such grant. Such plan shall be submitted to the Secretary as soon as practicable after the plan has been developed.

''(c) SINGLE GRANT LIMITATION.—A State is not eligible to receive a grant under this section if the State previously received a grant under this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

**"SEC. 399C–3. RESPONSIBILITIES OF THE SECRETARY.**

''(a) IN GENERAL.—The Secretary shall, with respect to stroke care—

''(1) develop a model curriculum for training emergency medical services personnel, including dispatchers, first responders, emergency medical technicians, and paramedics, in the identification, assessment, stabilization, and prehospital treatment of stroke patients; and

''(2) issue recommendations or guidelines on best practices for the establishment and operation of statewide stroke care systems, including recommendations or guidelines on best practices for the establishment and operation of stroke care centers.

''(b) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).

''(c) RULES OF CONSTRUCTION.—

''(1) EXISTING GUIDELINES.—Nothing in subsection (a)(2) shall be construed to require the Secretary to issue new recommendations or guidelines where existing recommendations or guidelines issued or adopted by the Secretary are applicable to the establishment of statewide stroke systems. Where an existing recommendation or guideline is applicable to

the establishment of statewide stroke systems, the Secretary may deem such recommendation or guideline to have been issued under subsection (a)(2).

''(2) ADVISORY NATURE OF GUIDELINES.—Recommendations or guidelines issued under subsection (a)(2) shall be considered advisory in nature and shall not be construed to constitute a standard of care for the treatment of stroke.''.

**SEC. 304. INCREASING LANGUAGE ACCESS FOR AMERICANS WITH LIMITED ENGLISH PROFICIENCY.**

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end thereof the following:

**''PART C—INCREASING LANGUAGE ACCESS FOR AMERICANS WITH LIMITED ENGLISH PROFICIENCY**

**''SEC. 251. IMPROVING ACCESS TO SERVICES FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.**

''(a) PURPOSE.—As provided in Executive Order 13166, it is the purpose of this section—

''(1) to improve access to Federally conducted and Federally assisted programs and activities for individuals who are limited in their English proficiency;

''(2) to require each Federal agency to examine the services it provides and develop and implement a system by which limited English proficient individuals can enjoy meaningful access to those services consistent with, and without substantially burdening, the fundamental mission of the agency;

''(3) to require each Federal agency to ensure that recipients of Federal financial assistance provide meaningful access to their limited English proficient applicants and beneficiaries;

''(4) to ensure that recipients of Federal financial assistance take reasonable steps, consistent with the guidelines set forth in the Limited English Proficient Guidance of the Department of Justice (as issued on June 12, 2002), to ensure meaningful access to their programs and activities by limited English proficient individuals; and

''(5) to ensure compliance with title VI of the Civil Rights Act of 1964 and that health care providers and organizations do not discriminate in the provision of services.

''(b) FEDERALLY CONDUCTED PROGRAMS AND ACTIVITIES.—

''(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, each Federal

agency that carries out health care-related activities shall prepare a plan to improve access to the federally conducted health care-related programs and activities of the agency by limited English proficient individuals.

''(2) PLAN REQUIREMENT.—Each plan under paragraph (1) shall provide for, at a minimum, the factors and principles set forth in the Department of Justice guidance published on June 12, 2002, and shall include the steps the agency will take to ensure that limited English proficient individuals have access to the agency's health care-related programs and activities. Each agency shall send a copy of such plan to the Department of Justice, which shall serve as the central repository of the agencies' plans.

''(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVITIES.—

''(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, each Federal agency providing health care-related Federal financial assistance shall ensure that the guidance for recipients of Federal financial assistance developed by the agency to ensure compliance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) is specifically tailored to the recipients of such as-

sistance and provides for, at a minimum, the factors and principles set forth in the Department of Justice guidance published on June 12, 2002. Each agency shall send a copy of such guidance to the Department of Justice which shall serve as the central repository of the agencies' plans. After approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

''(2) REQUIREMENTS.—The agency-specific guidance developed under paragraph (1) shall—

''(A) detail how the general standards will be applied to the agency's recipients; and

''(B) take into account the types of health care services provided by the recipients, the individuals served by the recipients, and other factors set out in such standards.

''(3) EXISTING GUIDANCES.—A Federal agency that has developed a guidance for purposes of title VI of the Civil Rights Act of 1964 that the Department of Justice determines provides for, at a minimum, the factors and principles set forth in the Department of Justice guidance published on June 12, 2002, shall examine such existing guidance, as well as the programs and activities to which such guid-

ance applies, to determine if modification of such guidance is necessary to comply with this subsection.

''(4) CONSULTATION.—Each Federal agency shall consult with the Department of Justice in establishing the guidances under this subsection.

''(d) CONSULTATIONS.—

''(1) IN GENERAL.—In carrying out this section, each Federal agency that carriers out health care-related activities shall ensure that stakeholders, such as limited English proficient individuals and their representative organizations, recipients of Federal assistance, and other appropriate individuals or entities, have an adequate and comparable opportunity to provide input with respect to the actions of the agency.

''(2) EVALUATION OF NEEDS.—Each Federal agency described in paragraph (1) shall evaluate the particular needs of the limited English proficient individuals served by the agency, and by a recipient of assistance provided by the agency, and the burdens of compliance with the agency guidance and its recipients of the requirements of this section.

**"SEC. 252. NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTHCARE.**

''Recipients of Federal financial assistance from the Secretary shall, to the extent reasonable and practicable after applying the 4-factor analysis described in title V of the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited-English Proficient Persons (June 12, 2002)—

''(1) implement strategies to recruit, retain, and promote individuals at all levels of the organization to maintain a diverse staff and leadership that can provide culturally and linguistically appropriate healthcare to patient populations of the service area of the organization;

''(2) ensure that staff at all levels and across all disciplines of the organization receive ongoing education and training in culturally and linguistically appropriate service delivery;

''(3) offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

''(4) notify patients of their right to receive language assistance services in their primary language;

''(5) ensure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff, and ensure that family and friends are not used to provide interpretation services—

''(A) except in case of emergency; or

''(B) except on request of the patient, who has been informed in his or her preferred language of the availability of free interpretation services;

''(6) make available easily understood patient-related materials including information or notices about termination of benefits and post signage in the languages of the commonly encountered groups or groups represented in the service area of the organization;

''(7) develop and implement clear goals, policies, operational plans, and management accountability and oversight mechanisms to provide culturally and linguistically appropriate services;

''(8) conduct initial and ongoing organizational self-assessments of culturally and linguistically appropriate services-related activities and integrate cul-

tural and linguistic competence-related measures into the internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations of the organization;

''(9) ensure that, consistent with the privacy protections provided for under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note)—

''(A) data on the individual patient's race, ethnicity, and primary language are collected in health records, integrated into the organization's management information systems, and periodically updated; and

''(B) if the patient is a minor or is incapacitated, the primary language of the parent or legal guardian is collected;

''(10) maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area of the organization;

''(11) develop participatory, collaborative partnerships with communities and utilize a variety of

formal and informal mechanisms to facilitate community and patient involvement in designing and implementing culturally and linguistically appropriate services-related activities;

''(12) ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients;

''(13) regularly make available to the public information about their progress and successful innovations in implementing the standards under this section and provide public notice in their communities about the availability of this information; and

''(14) regularly make available to the head of each Federal entity from which Federal funds are received, information about their progress and successful innovations in implementing the standards under this section as required by the head of such entity.

**''SEC. 253. INNOVATIONS IN LANGUAGE ACCESS GRANTS.**

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Centers for Medicare and Medicaid Services, the Administrator of the Health Resources and Services Administration, and the Director of the Of-

fice of Minority Health, shall award grants to eligible entities to enable such entities to design, implement, and evaluate innovative, cost-effective programs to improve linguistic access to health care for individuals with limited English proficiency.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

''(1) be a city, county, Indian tribe, State, territory, community-based nonprofit organization, health center or community clinic, university, college, or other entity designated by the Secretary; and

''(2) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

''(c) USE OF FUNDS.—An entity shall use funds received under a grant under this section to—

''(1) develop, implement, and evaluate models of providing real-time interpretation services through in-person interpretation, communications, and computer technology, including the Internet, teleconferencing, or video conferencing;

''(2) develop short-term medical interpretation training courses and incentives for bilingual health

care staff who are asked to interpret in the workplace;

''(3) develop formal training programs for individuals interested in becoming dedicated health care interpreters;

''(4) provide language training courses for health care staff;

''(5) provide basic health care-related English language instruction for limited English proficient individuals; or

''(6) develop other language assistance services as determined appropriate by the Secretary.

''(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to entities that have developed partnerships with organizations or agencies with experience in language access services.

''(e) EVALUATION.—An entity that receives a grant under this section shall submit to the Secretary an evaluation that describes the activities carried out with funds received under the grant, and how such activities improved access to health care services and the quality of health care for individuals with limited English proficiency. Such evaluation shall be collected and disseminated through the Center for Linguistic and Cultural Competence in Healthcare.

''(f) GRANTEE CONVENTION.—The Secretary, acting through the Director of the Center for Linguistic and Cultural Competence in Healthcare, shall at the end of the grant cycle convene grantees under this section to share findings and develop and disseminate model programs and practices.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

**''SEC. 254. STANDARDS FOR LANGUAGE ACCESS SERVICES.**

''Not later than 120 days after the date of enactment of this subtitle, the head of each Federal agency that carries out health care-related activities shall develop and adopt a guidance on language services for those with limited English proficiency who attempt to have access to or participate in such activities that provides at the minimum the factors and principles set forth in the Department of Justice guidance published on June 12, 2002.

**''SEC. 255. REPORT ON FEDERAL EFFORTS TO PROVIDE CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE SERVICES.**

''Not later than 1 year after the date of enactment of this subtitle and annually thereafter, the Secretary shall enter into a contract with the Institute of Medicine for

the preparation and publication of a report that describes federal efforts to ensure that all individuals have meaningful access to culturally and linguistically appropriate health care services. Such report shall include—

''(1) a description and evaluation of the activities carried out under this part; and

''(2) a description of best practices, model programs, guidelines, and other effective strategies for providing access to culturally and linguistically appropriate health care services.''.

**SEC. 305. FEDERAL REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.**

(a) MEDICARE.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

''MEDICARE PAYMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

''SEC. 1898. (a) PAYMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.—Notwithstanding any other provision of this title, by not later than January 1, 2006, the Secretary shall provide several alternative additions to the payment amounts for items and services for which payment may be made under the payment systems described in subsection (d) for items and services furnished to a LEP beneficiary (as defined by the

Secretary) for the estimated cost of providing quality culturally and linguistically appropriate language services (including in-person and telephonic interpreter services and written translation services.

''(b) APPLICATION TO SPECIFIC PROVIDERS.—The Secretary shall apply the addition described in subsection (a) to each specific individual or entity paid under a payment system described in subsection (d) that reflects the cost of most efficiently providing such quality services by that individual or entity.

''(c) CONSIDERATIONS IN DEVELOPING ALTERNATIVE AMOUNTS.—In developing the alternative amounts described in subsection (a), the Secretary shall—

''(1) consider which types of language access services are most appropriate for the improvement of the quality of care of LEP beneficiaries (as so defined), and ensure that interpretation is one of these services;

''(2) consider what those services should include and such other factors as the Secretary determines to be appropriate;

''(3) consider the cost to a hospital of contracting for such services, the cost of providing such services internally, the cost of providing such services through electronic and telecommunications

means, the extra cost of ensuring such services are available with respect to languages not frequently used in the United States, and the extra cost of ensuring such services are available in rural areas;

''(4) ensure the adequate adjustment of such additions for annual changes in the cost of providing such services.

''(d) PAYMENT SYSTEMS DESCRIBED.—The payment systems described in this subsection are the payments systems under this title, including the following:

''(1) INPATIENT HOSPITAL SERVICES.—The prospective payment system for inpatient hospital services under section 1886(d).

''(2) HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—The prospective payment system for hospital outpatient department services under section 1833(t).

''(3) PSYCHIATRIC HOSPITALS.—The payment system applicable with respect to psychiatric hospitals (as defined in section 1861(f)).

''(4) REHABILITATION FACILITIES.—The prospective payment system for rehabilitation facilities under section 1886(j).

''(5) CHILDREN'S, LONG-TERM CARE, AND CANCER HOSPITALS.—The payment systems applicable

with respect to hospitals described in clause (iii), (iv), or (v) of section 1886(d)(1)(B).

''(6) SKILLED NURSING FACILITIES.—The prospective payment system for skilled nursing facility services under section 1888(e).

''(7) HOME HEALTH SERVICES.—The prospective payment system for home health services under section 1895.

''(8) RENAL DIALYSIS FACILITIES.—The payment system for services provided to end-stage renal disease patients under section 1881.

''(9) PHYSICIANS' FEE SCHEDULE.—The physicians' fee schedule under section 1848.

''(10) MEDICARE ADVANTAGE PROGRAM.—The Medicare Advantage program under part C.

''(11) VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM.—The voluntary prescription drug benefit program under part D.''.

(b) MEDICAID.—Section 1903(a)(3) of the Social Security Act (42 U.S.C. 1396b(a)(3)) is amended—

(1) in subparagraph (D), by striking ''plus'' at the end and inserting ''and''; and

(2) by adding at the end the following:

''(E) 90 percent of the sums expended with respect to costs incurred during such quarter as

are attributable to the provision of culturally and linguistically appropriate services, including oral interpretation, translations of written materials, and other cultural and linguistic services for individuals with limited English proficiency and disabilities who apply for, or receive, medical assistance under the State plan (including any waiver granted to the State plan); plus''.

(c) SCHIP.—Section 2105(a)(1) of the Social Security Act (42 U.S.C.1397ee(a)), as amended by section 515, is amended—

(1) in the matter preceding subparagraph (A), by inserting ''or, in the case of expenditures described in subparagraph (D)(iv), 90 percent'' after ''enhanced FMAP''; and

(2) in subparagraph (D)—

(A) in clause (iii), by striking ''and'' at the end;

(B) by redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following:

''(iv) for expenditures attributable to the provision of culturally and linguistically appropriate services, including oral inter-

pretation, translations of written materials, and other language services for individuals with limited English proficiency and disabilities who apply for, or receive, child health assistance under the plan; and''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2005.

**SEC. 306. NATIONAL QUALITY ADVISORY COUNCIL.**

(a) ESTABLISHMENT.—There is hereby established the National Quality Advisory Council (in this section referred to as the ''Council'').

(b) MEMBERS.—

(1) NUMBER AND APPOINTMENT.—The Council shall be composed of 15 members to be appointed by the Comptroller General in accordance with this subsection.

(2) QUALIFICATION.—

(A) IN GENERAL.—The members of the Council shall include individuals with national recognition for their expertise in health care quality, quality measurement systems, consumer reporting, health care management, health plans and integrated delivery systems, health care financing, minority (and other vulnerable populations) health, and other related

fields who provide a mix of different professions and broad geographic and culturally diverse representation.

(B) INCLUSION.—The members of the Council shall include physicians and other health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical health services and health quality research and with expertise in outcomes and effectiveness research and technology assessment, and representatives of consumers from diverse backgrounds.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the members of the Council.

(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for the public disclosure, by members of the Council, of financial and other potential conflicts of interest relating to such members.

(3) TERMS.—

(A) IN GENERAL.—The terms of the members of the Council shall be for 5 years except that the Comptroller General shall stagger the terms of the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring in the Council before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has been appointed. A vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While carrying out the business of the Council (including travel time), a member of the Council shall be entitled to compensation at the per diem equivalent rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairperson of the Council. Physicians who are members of the Council may be provided a physician comparability allowance

by the Council in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code. For purposes of pay (other than pay of members of the Council) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(5) CHAIRPERSON; VICE CHAIRPERSON.—The Comptroller General shall designate a member of the Council, at the time of the appointment of such member, to serve as the Chairperson of the Council and another member to serve as Vice Chairperson of the Council for that term of appointment, except that in the case of the vacancy of the Chairpersonship or Vice Chairpersonship, the Comptroller General may designate another member to serve for the remainder of that member's term.

(6) MEETINGS.—The Council shall meet at the call of the Chairperson, but in no event less than once every 6 months.

(c) DUTIES.—

(1) REVIEW OF NATIONAL HEALTH CARE QUALITY.—The Council shall—

(A) identify national aims and objectives for health care quality improvement;

(B) track the progress of the United States in meeting the aims and objectives identified under subparagraph (A);

(C) make recommendations to Congress and the public concerning health care quality policies and programs for improvement; and

(D) not later than March 1 of each year (beginning in 2005), submit a report to Congress and the public containing the results of reviews conducted under this subsection and the recommendations of the Council concerning health care quality policies and programs.

(2) TOPICS TO BE REVIEWED.—

(A) NATIONAL AIMS.—The Council shall review, at the minimum, the following national aims:

(i) Reducing avoidable mortality and the underlying causes of illness, injury, and disability.

(ii) Expanding research on new treatments and evidence on effectiveness.

(iii) Assuring the appropriate use of health care services.

(iv) Reducing health care errors.

(v) Addressing oversupply and undersupply of health care resources.

(vi) Increasing patients' participation in their care and the public's engagement in improving health system performance.

(B) NATIONAL OBJECTIVES.—The Council shall develop measurable objectives within each of the national aims described in subparagraph (A) (as well as within any newly identified aims) and such objectives should be revised over time as improvements occur and new concerns arise.

(C) QUALITY MEASUREMENT AND REPORTING STANDARDS.—The Council shall conduct the following activities:

(i) Conduct assessments of the adequacy of current quality measures and reporting standards for the American population at large as well as for sub-populations defined by age, gender, race, ethnicity, income, disability, and geography.

(ii) Identify processes for the development of new quality measures and reporting standards as needed.

(iii) Make recommendations to health care organizations and providers regarding quality measurement and reporting, both publicly and privately.

(iv) Track the use of recommended quality measurement and reporting standards.

(v) Make recommendations to Congress concerning health care quality measurement and reporting requirements.

(D) DISPARITIES IN HEALTH CARE QUALITY.—The Council shall include as part of its overall review under this paragraph, an assessment of health care quality for, at the minimum, the following populations:

(i) Children and adolescents.

(ii) Senior citizens.

(iii) Disabled individuals.

(iv) Racial, ethnic and limited English proficient individuals.

(v) Women.

(vi) Low income individuals.

(vii) Geographically diverse populations.

(E) INTERVENTIONS FOR IMPROVEMENT OF HEALTH CARE QUALITY AND HEALTH SYSTEM PERFORMANCE.—The Council shall conduct the following activities:

(i) Review the evidence base to determine the most effective methods for improving patient care and the performance of the health care system, including regulation, accreditation, performance based payment, information technologies, management systems, professional certification, and public reporting of data.

(ii) Identify gaps and deficiencies of research to ascertain the most predictable processes and policies associated with improvements in quality.

(iii) Make recommendations to health care organizations and providers regarding quality improvement methods, including appropriate clinical guidelines, both publicly and privately.

(iv) Make recommendations to Congress concerning policies and processes for improvement.

(F) CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES.—The Council shall assess the implementation of this Act with attention to the following areas:

(i) Information disclosure.

(ii) Choice of providers and plans.

(iii) Access to emergency services.

(iv) Participation in treatment decisions.

(v) Respect and nondiscrimination.

(vi) Confidentiality of health information.

(vii) Complaints and appeals.

(viii) Consumer responsibilities.

(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary of Health and Human Service (referred to in this section as the ''Secretary'') submits to Congress (or a committee of Congress) a report that is required by law, and that relates to health care quality, including the National Healthcare Quality Report and the National Healthcare Disparities Report, the Secretary shall transmit a copy of the report to the Council. The Council shall review the report and, not later than 6 months after the date on which such report is

transmitted to the Council, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Council determines appropriate.

(4) AGENDA AND ADDITIONAL REVIEWS.—The Council shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress concerning the Council's agenda and progress towards achieving the agenda. The Council may conduct additional reviews and submit additional reports to the appropriate committees of Congress, from time to time, on such topics relating to the program under this title as may be requested by such chairperson and members and as the Council determines appropriate.

(5) AVAILABILITY OF REPORTS.—The Council shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(6) APPROPRIATE COMMITTEES OF CONGRESS.—In this section, the term ''appropriate committees of Congress'' means the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Com-

mittee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate.

(d) DIRECTOR; STAFF; EXPERTS; CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Council, the Council may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provision of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Council (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Council;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as the Council determines necessary with respects to the internal organization and operation of the Council.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—The Council may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairperson, the head of such a department or agency shall furnish such information to the Council on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, the Council shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Council or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for the Coun-

cil's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Council, immediately upon request.

(4) PERIODIC AUDIT.—The Council shall be subject to periodic audit by the Comptroller General.

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—The Council shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Council shall be separate from amounts appropriated for the Comptroller General.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

# TITLE IV—PREVENTIVE HEALTH SERVICES

## SEC. 401. INCREASING HEALTH INSURANCE COVERAGE FOR PREVENTION.

(a) APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by section 121, is further amended by adding at the end the following new section:

**"SEC. 2708. STANDARDS RELATING TO BENEFITS FOR PREVENTIVE SERVICES.**

''(a) REQUIREMENTS FOR COVERAGE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, shall provide coverage for preventive health care items and services specified by the Secretary under section 401(c) of the Health Care Modernization, Cost Reduction, and Quality Improvement Act.

''(b) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (b) (relating to notice), (c) (relating to prohibitions), (d) (relating to rules of construction), and (e) (relating to preemption) of section 713 of the Employee Retirement Income Security Act of 1974 shall apply to subsection (a) in the same manner as such subsections apply to subsection (a) of such section 713, except that the date provided for in subsection (b)(3) shall be January 1, 2005.''.

(2) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting

''(other than sections 2707 and 2708)'' after ''requirements of such subparts''.

(b) APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 123, is further amended by adding at the end the following new section:

**''SEC. 715. STANDARDS RELATING TO BENEFITS FOR PREVENTIVE SERVICES.**

''(a) REQUIREMENTS FOR COVERAGE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, shall provide coverage for preventive health care items and services specified by the Secretary under section 401(c) of the Health Care Modernization, Cost Reduction, and Quality Improvement Act.

''(b) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (b) (relating to notice), (c) (relating to prohibitions), (d) (relating to rules of construction), and (e) (relating to preemption) of section 713 shall apply to subsection (a) in the same manner as such subsections apply to subsection (a) of such section 713, except that

the date provided for in subsection (b)(3) shall be January 1, 2005.''.

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711, 714 and 715''.

(B) TABLE OF CONTENTS.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Standards relating to benefits for preventive services.''.

(c) PREVENTIVE HEALTH CARE ITEMS AND SERVICES.—Not later than January 1, 2005, the Secretary of Health and Human Services, in consultation with the United States Preventive Services Task Force, shall specify those preventive health care items and services to be covered by group health plans and health insurance issuers under the amendments made by this section. In specifying such items and services, the Secretary shall consider the cost and effectiveness of such items and services.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans

and health insurance issuers for plan years beginning on or after January 1, 2005.

**SEC. 402. ACTIVITIES RELATING TO NUTRITION AND PHYSICAL ACTIVITY.**

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 303, is further amended by adding at the end the following:

**"PART U—PREVENTIVE HEALTH CARE**

**"SEC. 399D. ENCOURAGING HEALTHY DIETS.**

''(a) IN GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention, the Secretary of Education, and the Secretary of Agriculture, shall establish and implement activities to encourage health dietary choices (such as fruits and vegetables, and foods that are low in fat, sugar, and salt) in schools, worksites, and communities.

''(b) SCHOOLS.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention, the Secretary of Agriculture, and the Secretary of Education, shall require elementary and secondary schools that receive Federal funds to—

''(1) ban soft drinks or other foods of minimal nutritional value from vending machines;

''(2) maintain a minimum number of functioning water fountains in school buildings;

''(3) prohibit advertisements in schools and on school grounds for foods of minimal nutritional value such as fast foods, beverages, and snack foods of which greater than 50 percent of the calories are derived from fat or simple sugars; and

''(4) integrate into school curricula education about lifelong healthy eating.

''(c) WORKSITES.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention, the Secretary of Agriculture, and the Secretary of Labor, shall—

''(1) ensure the availability of meal selections in cafeterias, snack stands, and vending machines in Federal Government buildings that meet the recommendations of the Secretary for nutritional content and portion size;

''(2) require clear and effective labeling of calories, fat, trans fat, sugar, sodium, and portion size for meal selections served in cafeterias and all foods and beverages sold in vending machines, and at snack stands in Federal Government buildings, as determined appropriate by the Secretary;

''(3) work with unions, employee associations, and employer associations to provide technical assistance for the establishment of employee incentive

programs to increase participation in worksite health promotion programs that encourage diets in accordance with national standards promulgated by the Secretary; and

''(4) establish incentive programs to enable employers to partner with local farmers, farmers markets, grocers, and restaurants to increase accessibility and availability of fresh fruits and vegetables through worksite cafeterias, snack bars, and vending machines.

''(d) COMMUNITIES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants for projects that—

''(1) implement campaigns, in communities at risk for poor nutrition, that are designed to promote the intake of foods consistent with established dietary guidelines through the use of different types of media including television, radio, newspapers, movie theaters, billboards, and mailings;

''(2) implement campaigns, in communities at risk for poor nutrition, that promote water as the main daily drink choice through the use of different types of media including television, radio, newspapers, movie theaters, billboards, and mailings;

''(3) conduct outreach to commercial food establishments, grocery stores, and other food suppliers, to increase the availability and accessibility of healthy foods and beverages;

''(4) partner with national programs that provide parents and mentors with the skills to help guide and influence healthy meals and snack selections for children and adolescents; or

''(5) partner with national afterschool and summer programs that provide children with the education and skills needed to make healthy meal and snack selections.

''(e) HEALTH PROFESSIONALS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to—

''(1) support the development, implementation, and evaluation of curricula to educate and train health professionals about effective nutrition education and counseling strategies for obese individuals and parents of overweight children, with emphasis on the Dietary Guidelines for Americans or other nationally accepted standards; or

''(2) use web-based and related technologies to develop, implement, and evaluate the effectiveness of dietary counseling in health care settings.

''(f) EVALUATION.—Not later than 12 months after the date on which a grant is awarded under this section, the grantee shall submit to the Director of the Centers for Disease Control and Prevention a report that describes the activities carried out with funds received under the grant and the effectiveness of such activities in improving the intake of nutritional foods.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

**''SEC. 399D–1. INCREASING PHYSICAL ACTIVITY.**

''(a) IN GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention, the Secretary of Education, the Secretary of Labor, and the Director of the Federal Highway Administration, shall establish and implement activities for the purpose of increasing physical activity in schools, worksites, and communities.

''(b) SCHOOLS.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary of Education shall award grants to public elementary and secondary schools for programs that support—

''(1) the provision of daily physical education for students in kindergarten through grade 12

through programs that are consistent with the Guidelines for Physical Activity as reported by the Centers for Disease Control and Prevention and the American College of Sports Medicine and National Physical Education Standards;

''(2) the implementation of comprehensive school curricula and school-based physical activity programs that provide education about lifelong physical activity;

''(3) training for school personnel that provides the knowledge and skills needed to effectively teach lifelong physical activity; or

''(4) evaluations of school physical education programs and facilities at annual intervals to determine the extent to which national guidelines described in paragraph (1) are met.

''(c) WORKSITES.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, and the Secretary of Labor, shall award grants to eligible entities as determined by the Director, which may include labor organizations, trade associations, trade groups, and businesses for the establishment of projects that include—

''(1) the development of activity friendly worksites (which may include the provision of facilities

for physical activity, accessible and attractive stairwells, walking trails, and supportive management practices) that encourage employee participation in physical activity;

''(2) the development of worksite wellness programs that improve physical activity by increasing the knowledge, attitudes, skills, and behaviors of employees; and

''(3) the development of employee incentive programs (such as cafeteria discounts, health club memberships, small cash bonuses, and time off) to increase the participation of employees in worksite health promotion programs that increase physical activity.

''(d) COMMUNITIES.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, the Secretary of Transportation, and Secretary of the Interior, shall award grants for the implementation and evaluation of activities that may include—

''(1) projects to design pedestrian zones and construct safe walkways and cycling paths;

''(2) projects that create greenways and open-space areas linking parks, nature preserves, and cultural or historic sites with each other and with popu-

lated areas such as residential communities and business locations;

''(3) initiatives to increase the use of walking and bicycling as a transportation mode by creating or enhancing informational outreach to parks or community recreation centers; and

''(4) community-wide campaigns designed to increase physical activity as part of multicomponent efforts that include strategies such as support of self help groups, physical activity counseling, risk factor screening and education, and environmental or policy changes such as the creation of walking trails.

''(e) EVALUATION.—Not later than 2 years after the date on which a grant is awarded under this section, the grantee shall submit to the Director of the Centers for Disease Control and Prevention a report that describes the activities carried out with funds receive under the grant and the effectiveness of such activities in increasing physical activity.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.''.

**SEC. 403. IMPROVING IMMUNIZATION.**

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 402, is further amended by adding at the end the following:

## "PART V—IMPROVING IMMUNIZATION

### "SEC. 399E. PROGRAMS TO IMPROVE THE RATE OF IMMUNIZATION IN ADULTS AND ADOLESCENTS.

''(a) DEMONSTRATION PROJECTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award supplemental grants under section 317 to eligible entities for the development, implementation, and evaluation of evidence-based programs that improve the rate of immunization of adults and adolescents.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section an entity shall—

''(1) be—

''(A) a hospital;

''(B) an academic institution;

''(C) a nonprofit community based organization;

''(D) a health center; or

''(E) any other public or private nonprofit entity determined appropriate by the Director of the Centers for Disease Control and Prevention;

''(2) establish a partnership with a State or local government for purposes of carrying out activities under this section; and

''(3) prepare and submit to the Director of the Centers for Disease Control and Prevention an application at such time, in such manner, and containing such information as the Director may require.

''(c) USE OF FUNDS.—An entity shall use amounts received under a grant under this section to conduct projects to carry out activities consistent with evidence-based strategies recommended by the Advisory Committee on Immunization Practices and the Task Force on Community Preventive Services, including—

''(1) the conduct of public information and education campaigns that will promote adult and adolescent immunizations recommended by the Advisory Committee on Immunization Practices, through the development and dissemination to targeted audiences of appropriate messages about the risks and benefits of immunizations;

''(2) the conduct of programs to offer vaccines to underimmunized adult and adolescent populations in settings that have not previously or routinely provided these services, such as family planning, HIV,

sexually transmitted disease, and drug treatment centers, emergency departments, pharmacies, home care agencies, senior citizen homes, and correctional facilities;

''(3) the conduct of provider-based interventions to promote adult and adolescent vaccinations recommended by the Advisory Committee on Immunization Practices, which shall include—

''(A) the development and implementation of reminder or recall systems that align with State and local immunization information systems and inform health care providers when adult and adolescent patients are due or overdue for specific vaccinations; and

''(B) the establishment of standing orders in which non-physician medical personnel deliver adult and adolescent vaccinations without direct physician involvement at the time of the visit; and

''(4) the conduct of programs to identify other interventions and to translate interventions into practice.

''(d) DISSEMINATION.—The Director of the Centers for Disease Control and Prevention shall publish and disseminate findings made as a result of activities conducted

under this section to the public in coordination with the heads of other appropriate Federal agencies.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

**''SEC. 399E–1. CURRICULUM DEVELOPMENT.**

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall award competitive cooperative agreements for the development of innovative curricula for health care provider training and continuing education for practicing professionals concerning the assessment, monitoring, improvement, and delivery of immunizations for adults, adolescents, and children.

''(b) ELIGIBILITY.—To be eligible to receive a cooperative agreement under this section an entity shall—

''(1) be—

''(A) an academic institution, such as a school of medicine, nursing, or pharmacy; or

''(B) any other public or private nonprofit entity determined to be appropriate by the Director of the Centers for Disease Control and Prevention; and

''(2) prepare and submit to the Director of the Centers for Disease Control and Prevention an ap-

plication at such time, in such manner, and containing such information as the Director of the Centers for Disease Control may require.

''(c) USE OF FUNDS.—An entity shall use amounts received under a cooperative agreement under this section to develop, implement, and evaluate curricula for health care providers that use innovative educational methods, to promote the awareness and implementation of immunizations for adults, adolescents, and children. Such curricula may include distance learning courses and CD–Rom and web-based educational programs.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

**''SEC. 399E–2. ASSURING ADEQUATE SUPPLY OF VACCINES FOR ADULT AND ADOLESCENT IMMUNIZATION PROGRAMS.**

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall award competitive supplemental grants to immunization grantees under section 317 to ensure that there is an adequate supply of vaccines for adults and adolescents.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an entity determined appropriate by the Director of the Centers for Disease Control and Prevention; and

''(2) prepare and submit to the Director of the Centers for Disease Control and Prevention an application at such time, in such manner, and containing such information as the Director may require.

''(c) USE OF FUNDS.—An entity shall use amounts received under a grant under this section to ensure the availability of vaccines and related supplies to support the implementation of programs to improve the rate of immunization in adults and adolescents.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

**''SEC. 399E–3. RESEARCH ON IMMUNIZATION PROGRAMS.**

''(a) EFFICACY RESEARCH PROJECTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award cooperative agreements to eligible entities for the conduct of research and other activities to improve immunization program's for adults and adolescents.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section an entity shall—

''(1) be—

''(A) an academic institution;

''(B) a nonprofit community based organization;

''(C) a State or local health agency; or

''(D) any other public or private nonprofit entity determined to be appropriate by the Director of the Centers for Disease Control and Prevention; and

''(2) prepare and submit to the Director of the Centers for Disease Control and Prevention an application at such time, in such manner, and containing such information as the Director may require.

''(c) USE OF FUNDS.—An entity shall use amounts received under a grant under this section to conduct prospective and other research projects on the effect of immunization programs in high-risk and underimmunized populations on the rates of immunization, incidence of influenza, pneumococcal disease, hepatitis A, hepatitis B, and other vaccine-preventable diseases and related complications.

''(d) DISSEMINATION.—The Director of the Centers for Disease Control and Prevention shall disseminate findings made as a result of activities conducted under this section to the public in coordination with the heads of other appropriate Federal agencies.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

**''SEC. 399E–4. DEFINITION.**

''In this part, the term 'State' has the meaning given such term in section 2, and includes Indian tribes.''.

**SEC. 404. IMPROVING ORAL HEALTH.**

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 403, is further amended by adding at the end the following:

**''PART W—IMPROVING ORAL HEALTH**

**''SEC. 399F. PUBLIC EDUCATION.**

''(a) DEMONSTRATION PROJECTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award competitive grants to eligible entities for the conduct of public education campaigns to raise public awareness concerning oral health.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

"(1) be—

"(A) a State health agency;

"(B) an academic institution;

"(C) a nonprofit or community organization; or

"(D) any other public or private nonprofit entity determined to be appropriate by the Director of the Centers for Disease Control and Prevention; and

"(2) prepare and submit to the Director of the Centers for Disease Control and Prevention an application at such time, in such manner, and containing such information as the Director may require.

"(c) USE OF FUNDS.—An entity shall use amounts received under a grant under this section to partner with a State to—

"(1) increase public awareness of oral health issues through public outreach campaigns, particularly targeting adult populations including those with intellectual disabilities, and those with chronic diseases such as diabetes; and

"(2) develop, implement, and evaluate programs that promote oral health in adults.

''(d) DISSEMINATION.—The Director of the Centers for Disease Control and Prevention shall disseminate findings made as a result of activities conducted under this section to the public in coordination with the heads of other appropriate Federal agencies.

''(e) EVALUATION.—A grantee under this section shall submit to the Director of the Centers for Disease Control and Prevention an evaluation that describes activities carried out with funds received under the grant and the effectiveness of such activities in improving oral health among adults including those with intellectual disabilities or with chronic disease.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

**''SEC. 399F–1. HEALTH CARE PROVIDER EDUCATION.**

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall award competitive grants to entities for the development of innovative curricula for health care providers concerning the delivery of oral care to adults, including adults with intellectual disabilities or with chronic disease.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

''(1) be—

''(A) an academic institution;

''(B) a health center; or

''(C) any other entity determined appropriate by the Director of the Centers for Disease Control and Prevention; and

''(2) prepare and submit to the Director of the Centers for Disease Control and Prevention an application at such time, in such manner, and containing such information as the Director may require.

''(c) USE OF FUNDS.—An entity shall use amounts received under a grant under this section to develop, implement, and evaluate innovative curricula for health care providers that promotes oral health for adults, including adults with intellectual disabilities or with chronic disease.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

**''SEC. 399F–2. MONITORING AND EVALUATING THE QUALITY OF ORAL HEALTH.**

''(a) DEMONSTRATION PROJECTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award competitive grants to

States to expand the ability of States to improve the quality of oral health among adults including adults with intellectual disabilities or with chronic disease.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section a State shall prepare and submit to the Director of the Centers for Disease Control and Prevention an application at such time, in such manner, and containing such information as the Director may require.

''(c) CONTRACTING AUTHORITY.—A State receiving a grant under this section may enter into contracts with academic institutions, and other entities determined to be appropriate by the Director, to carry out activities authorized under this section.

''(d) USE OF FUNDS.—A State shall use amounts received under a grant under this section for activities to improve the oral health of adults, including adults with intellectual disabilities or chronic diseases. Such activities may include—

''(1) the collection of public health surveillance information;

''(2) the analysis of data to determine the oral health status of adults;

''(3) the development and implementation of interventions to improve oral health;

''(4) the dissemination of evidence-based best practices; and

''(5) the coordination of the sharing of oral health data and evidence based practices between States.

''(e) PRIVACY.—A State receiving a grant, or an entity entering into a contract, under this section shall comply with appropriate security and privacy protocols (including protocols required under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note)), if applicable, with respect to information collected under this section. Nothing in this section shall be construed to supersede applicable Federal or State privacy laws.

''(f) EVALUATION.—A grantee under this section shall submit to the Director of the Centers for Disease Control and Prevention an evaluation that describes the activities conducted with funds received under the grant and the effectiveness of such activities in improving oral health among adults, including adults with intellectual disabilities or with chronic disease.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section

and such sums as may be necessary for each of fiscal years 2005 through 2009.

**"SEC. 399F–3. STUDIES AND REPORTS BY THE INSTITUTE OF MEDICINE.**

"(a) CONTRACT.—The Secretary shall enter into a contract with the Institute of Medicine to assess existing gaps in, and impediments to, quality oral health, including gaps in data, research and translation, and care provided to adult populations.

"(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

**"SEC. 399F–4. DEFINITION.**

"In this part, the term 'State' has the meaning given such term in section 2, and includes Indian tribes.".

○